Summary Plan Description

Hanford Employee Welfare Trust
Flexible Spending Account Plan

Effective: January 1, 2023
Group Number: 702637

FLEXIBLE SPENDING ACCOUNT PLAN

Notice To Employees

This Summary Plan Description ("SPD") describes the major features of the Hanford Employee Welfare Trust Flexible Spending Account Plan ("Plan") as of January 1, 2023. The Plan is a component of the Hanford Employee Welfare Trust ("HEWT"). If there are any omissions or any inconsistency between the provisions of the HEWT plan document and any provision of this SPD, the provisions of the HEWT plan document will govern.

The HEWT has entered into an arrangement with United HealthCare Services, Inc, Hartford, CT ("UnitedHealthcare") under which UnitedHealthcare will process reimbursements and provide certain other administrative services to the Plan.

The benefits described in this booklet are not insured. This document should not be construed as tax, medical, or legal advice. Please consult your advisor regarding your personal situation.

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PLAN HIGHLIGHTS

Under the Plan, you can elect to establish up to two flexible spending accounts ("FSAs"). These accounts let you make before-tax contributions from your salary, which can then be used to reimburse you for Eligible Expenses. Participation in the Plan is optional.

The **Health Care Spending Account ("HCSA")** is a type of FSA used for reimbursement of any Eligible Health Care Expenses (defined in the ***Health Care Spending Account and Limited Health Care Spending Account*** section) for you, your spouse, and your dependents.

The **Limited Health Care Spending Account ("LHCSA")** is a type of FSA used for reimbursement for only dental, vision, and certain preventive care expenses (defined in ***Health Care Spending Account and Limited Health Care Spending Account*** section) for you, your spouse, and your dependents. Note that if you participate in the high deductible health plan and elect a Health Savings Account ("HSA") you may only elect a LHCSA.

The **Dependent Care Spending Account ("DCSA")** is a type of FSA used for reimbursement of Eligible Dependent Care Expenses (defined in the ***Dependent Care Spending Account*** section), such as day care.

You can elect to participate in up to two of the following:

- Either the HCSA or the LHCSA, and/or
- The DCSA

Each Plan Year (January 1 through December 31) you can contribute to your HCSA or LHCSA, and/or DCSA, and then, during the Plan Year, you can receive reimbursement from the appropriate account for Eligible Expenses that are not otherwise reimbursed. Contribution levels are set forth as described under Section, *Contributions*.

WHO IS ELIGIBLE AND HOW TO START YOUR FLEXIBLE SPENDING ACCOUNT

Who is Eligible

A regular full-time or part-time employee of a participating employer in the HEWT who is scheduled to work at his or her job at least 20 hours per week is eligible to participate in the Plan.

Per 10 CFR 850.35(b)(2), individuals that are out on Medical Removal are eligible for FSAs.

When You May Enroll

You may elect to participate in the Plan during your first 31 days of employment or during any subsequent annual enrollment period. If timely elected, the Plan will be effective on your date of hire. If you do not elect to participate in the Plan during your first 31 days of

employment, you must wait until the next annual Open Enrollment period to elect to participate in the Plan, unless you have experienced a qualified change in status. (Refer to the Section, *Changing Your Contribution Amounts*.) You will need to enroll each year, even if you enrolled in the Plan the year before.

How to Enroll

You elect to participate in the Plan by completing an enrollment form and submitting it to the Benefits Department. You must specify the amount of before-tax dollars you wish to contribute to the HCSA or the LHCSA, and/or the DCSA.

To enroll, call the Benefits Department within 31 days of the date you first become eligible to participate in the Plan. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to participate in the Plan.

Each year during annual Open Enrollment, you have the opportunity to review and change the amount of before-tax dollars you wish to contribute to the HCSA or LHCSA, and/or the DCSA. Any changes you make during Open Enrollment will become effective the following January 1.

CONTRIBUTIONS

Each year, you must decide on the amount of before-tax dollars you want to contribute to the accounts. Please note that these accounts are not "funded." Rather, the amount you elect to "contribute" remains in the HEWT's general assets until claims are reimbursed. You may contribute to the HCSA or the LHCSA, and/or DCSA, however, amounts contributed to one account cannot be used to reimburse expenses under the other account. You should carefully estimate your Eligible Health Care and Dependent Care Expenses, collectively referred to throughout this booklet as "Eligible Expenses," for the upcoming Plan Year because IRS regulations require that you forfeit any unused funds remaining in the DCSA and any unused funds in excess of $500 remaining in the HCSA or LHCSA after the end of the 2022 Plan Year.

You have until March 31 of the next year to request reimbursement for Eligible Expenses incurred during the Plan Year.

For either the HCSA or LHCSA, you may elect to contribute between $120 and the maximum permitted under Section 125(i) of the Internal Revenue Code (the "Code") ($3,050 for 2023) as disclosed to you prior to enrollment. The amount you elect to contribute for a Plan Year will be added to your carryover amount, if any, from the preceding Plan Year to determine the amount in your HCSA or LHCSA that may be used to reimburse your Eligible Expenses for the Plan Year (see Section, *Carryover of Health Care Spending Account Balances*, for details).

If your employment terminates during the year, you may submit a claim for reimbursement of Eligible Health Care Expenses which were incurred up to the date you terminate employment for reimbursement. Those claims may be submitted on or before March 31 of the next Plan Year. However, if you are eligible for COBRA continuation coverage and elect to continue coverage, then you may submit claims for Eligible Health Care Expenses

incurred while on COBRA continuation coverage. If you elect COBRA continuation coverage through the end of the Plan Year, then you have until March 31 of the next year to submit claims for Eligible Health Care Expenses (see Section, *COBRA Continuation Coverage*, for details).

For the DCSA, you may elect to contribute between $120 and $5,000 per year, or if you are married and filing separately for federal income tax purposes, you may each elect to contribute up to $2,500 per year. If you or your spouse's earned income is less than $5,000 per year, the amount that you can contribute is reduced to the amount of your or your spouse's earned income. If your employment terminates, you may submit expenses incurred up to the date you terminate employment for reimbursement, and that those claims can be submitted until March 31 of the calendar year following the calendar year in which you terminate employment.

CHANGING YOUR CONTRIBUTION AMOUNTS

IRS regulations do not permit you to stop or change the amount you contribute to an FSA during the Plan Year, unless the Plan Administrator has determined that you have had a qualifying "change in status" during the Plan Year and that your revocation is on account of and corresponds with the change. The following events qualify as a change in status, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations.

A. With regard to a HCSA, a LHCSA, and a DCSA, one of the following changes in status events occurs:

- An event that results in a change in your legal marital status, including your marriage, the death of your spouse, or your divorce, legal separation, or annulment.
- An event that results in a change in the number of your dependents, including marriage of a dependent, birth, adoption, placement for adoption, or death of a dependent.
- An event that results in a change in the employment status of you, your spouse, or dependent, including termination or commencement of employment, reduction or increase in hours of employment by you, your spouse, or dependent (including switches between full-time and part-time), a strike or lockout, the commencement of or return from an unpaid leave of absence.
- An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements (for example, due to the attainment of age).
- An event that causes a change in place of residence or work for you, your spouse, or your dependents.

B. For individuals who participate in a HCSA, the following additional events will enable you to change your election:

- If you become entitled to Medicare or Medicaid, you may elect to revoke your HCSA coverage. If you lose coverage under Medicare or Medicaid, you may increase your coverage.

- If the FSA Plan Sponsor and/or Hanford Employee Welfare Trust receives a judgment, decree or order resulting from your divorce, legal separation, annulment or change in legal custody that requires group health coverage for your dependent child, then the FSA Plan Administrator and/or Hanford Employee Welfare Trust may:
  - ♦ Change your election to provide coverage for that child, if the order requires you to provide coverage for the child under the HCSA, or
  - ♦ Permit you to cancel your child's coverage under the HCSA, if the order requires your former spouse to provide coverage.

C. With regard to a DCSA, the following events, in addition to those in (A), above will enable you to change your election:

- A change in your dependent care provider.
- A significant increase or decrease in the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to you.

You must notify the HEWT within 31 days of the above change in status events to request a change in coverage. No change in election will be permitted after 31 days.

The above rules are intended to be consistent with the IRS regulations under Sections 125 and 129 of the Code, and to the extent there is any inconsistency, those regulations shall control.

Any new election hereunder must be on account of and correspond with the change in status event that affects eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the election change you are requesting (i.e., if you divorce, it would not be logical to increase your HCSA or LHCSA election). As used herein, "dependent" means a tax dependent under Section 152 of the Code.

Changes in contribution amounts made during the Plan Year are effective as of the first of the month following the date that you timely notify the Plan Administrator of the change in status.

HEALTH CARE SPENDING ACCOUNT AND LIMITED HEALTH CARE SPENDING ACCOUNT

Eligible Health Care Expenses for HCSA

To be eligible for reimbursement from your HCSA, the health care expenses must be:

- ■ Incurred for medical care, defined in Sections 106(f) or 213(d) of the Code for amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body including prescription medicine and drugs and over-the-counter medicine and drugs prescribed by a health care provider.

- Incurred while you are participating in the HCSA (including via COBRA continuation coverage).
- Incurred during the Plan Year.

Please note:
Any reimbursement you receive through your HCSA or LHCSA cannot be reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan.

Below is a partial list of the types of health care expenses eligible for reimbursement from your HCSA. Generally, Eligible Health Care Expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) including any copayment, coinsurance, or deductible amounts.

A more comprehensive list of Eligible Expenses are available at **www.myuhc.com** (note that website registration may be required). Some guidance regarding what constitutes eligible medical expenses (including additional examples) is provided in IRS Publication 502, which is available from any regional IRS office, the IRS website at **www.irs.gov**, or by phone at 1-800-TAX-FORM (1-800-829-3676). However, there are certain exceptions (e.g., over-the-counter medicine or drugs prescribed by a health care provider that may be reimbursable from your HCSA, but insurance premiums are not).

Eligible Medical Expenses

- Copayments, Coinsurance and Deductible amounts;
- Routine physical exams;
- Routine lab and x-rays performed for medical reasons;
- Birth control items prescribed by your doctor;
- Childbirth classes;
- Cardiac rehabilitation classes;
- Drug abuse treatment centers;
- Sterilization unless prohibited by law;
- Permitted over-the-counter medicines and drugs that are qualified medical expenses under Section 213(d) of the Code;
- Menstrual care products within the meaning of Section 106(f) of the Code;
- Other qualified medical expenses under Section 213(d) of the Code that are not covered by the underlying medical plan.

Eligible Vision Expenses

- Routine eye examinations;
- Eye glasses;
- Contact lenses, including all necessary supplies and equipment.

Eligible Hearing Expenses

- Routine hearing examinations;
- Hearing aids and repairs;
- Cost and repair of special telephone equipment for the deaf.

Eligible Dental Expenses

- Copayments, Coinsurance and Deductible amounts;
- Preventive Care;
- Exams, cleanings, x-rays, root canals and bridges;
- Dentures and fillings.

Eligible Prescription Drugs

- Copayments, Coinsurance and Deductible amounts;
- Cost for allowable prescription drugs.

Ineligible Expenses

The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses for custodial care in a nursing home.
- Insurance premiums, including Medicare Part B premiums, long term care premiums, and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or HMO or other health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements, and toothpaste).
- Expenses incurred before the effective date of your account.

In addition, as with any other expense reimbursed under an employer-sponsored medical or dental plan, health expenses reimbursed through your HCSA cannot be claimed as deductions on your income tax return.

Eligible Health Care Expenses for LHCSA

To be eligible for reimbursement from your LHCSA, the health care expenses must be:

- Services or treatments for Eligible Dental Expenses.
- Services or treatments for Eligible Vision Expenses.

- Services or treatments for "preventive care." Preventive care is defined in accordance with applicable rules and regulations under IRC Section 223(c)(2)(C). This may include prescribed drugs to the extent that such drugs are taken (1) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the eligible individual is asymptomatic); (2) to prevent the recurrence of a condition from which the eligible individual has recovered; or (3) as part of a preventive care treatment program (e.g., a smoking-cessation or weight-loss program). Preventive care does not include services or treatments that treat an existing condition.

- Incurred while you are participating in the LHCSA (including via COBRA continuation coverage).

- Incurred during the Plan Year.

Carryover of Health Care Spending Account Balances

Any amounts remaining in your HCSA or LHCSA after all of your claims for Eligible Expenses for the Plan Year have been submitted, up to a maximum of $500, will be carried over and will be available to reimburse Eligible Expenses incurred in a subsequent Plan Year. Any amounts remaining in your HCSA or LHCSA in excess of $500 after the end of the Plan Year will be forfeited. The amount that is carried over, if any, is determined after the deadline to request reimbursement for Eligible Expenses incurred in a Plan Year (March 31 of the year following the Plan Year).

Your carryover amount, if any, from the preceding Plan Year is added to the amount you contribute (between $120 and the maximum permitted under Section 125(i) of the Code ($3,050 for 2023)) for the Plan Year to determine the amount in your HCSA or LHCSA that may be used to reimburse your Eligible Health Care Expenses for the Plan Year. For example, if you have $600 remaining in your HCSA after all of your Eligible Expenses for the 2022 Plan Year have been submitted, $500 may be carried over and used to reimburse your Eligible Expenses incurred in the 2023 Plan Year. If you also elect to contribute the maximum $3,050 for the 2023 Plan Year, a total of $3,550 is available to reimburse your Eligible Expenses for 2023 (the remaining $100 in you HCSA in 2022 will be forfeited).

DEPENDENT CARE SPENDING ACCOUNT

Eligible Dependent Care Expenses

Eligible Dependent Care Expenses that can be reimbursed from your DCSA are expenses incurred for household and dependent care services that enable you and (if married) your spouse to be gainfully employed, which generally means working or actively looking for work.

If your spouse has no earned income, you cannot use a DCSA unless your spouse is physically or mentally incapable of caring for himself or herself, is looking for work or is a full-time student for at least five months during the Plan Year.

To qualify for reimbursement, Dependent Care Expenses cannot exceed your earned income or, if married, the earned income of the lesser earning spouse. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. If you are married and your spouse is physically or mentally incapable of caring for himself or herself or is a full-time student, the IRS considers your spouse to have a monthly income of $250 (as adjusted from time to time) if you have one dependent, or $500 (as adjusted from time to time) if you have two or more dependents, for each month that your spouse is incapable of caring for himself or herself or is a full-time student.

Dependent Care Expenses must be incurred for a qualified dependent. Qualified dependents are:

- A dependent under federal tax law who is a child under age 13; or
- A spouse of a participant, if the spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the taxpayer for more than one-half of such taxable year; or
- A dependent under federal tax law who is physically or mentally incapable of caring for himself or herself; provided that such dependent lives in your home for more than one-half of the year, if you provide over one-half of the individual's support for the taxable calendar year.

Eligible Dependent Care Expenses include, but are not limited to, the following expenses if not otherwise excluded:

- Expenses for care at a day care center and day care transportation that complies with all applicable state and local regulations.
- Expenses for licensed nursery school fees.
- Expenses for care provided by a housekeeper, babysitter or other person in your home who primarily cares for eligible children or an eligible adult dependent.
- Expenses for care provided by a relative who cares for your qualified dependents, so long as that relative is over the age of 19 and is not your dependent under federal tax law.
- Expenses for care for a qualified dependent age 13 or over, including a spouse or adult dependent, who is physically or mentally incapable of caring for himself or herself. If you are claiming reimbursement for care outside your home for such dependent, the dependent must spend at least 8 hours each day in your home.
- Expenses for care at a day camp to which you send your children (under age 13) during school vacations so that you and your spouse, if you are married, can be gainfully employed or attend school full-time.

Dependent Care Tax Credit vs. Dependent Care Spending Account

Some employees may be eligible to claim a dependent care tax credit on their federal income tax return. This credit is available for the same types of expenses as the DCSA. However,

the IRS requires that the dependent care tax credit be reduced, dollar for dollar, by the amount reimbursed under a DCSA. In other words, you cannot use expenses reimbursed through the DCSA to claim the tax credit.

For more information about how the dependent care tax credit works, see IRS Publication No. 503. In addition, because each employee's situation is different, you may want to consult with a tax advisor before deciding whether to use the tax credit or the DCSA.

HEALTH CARE SPENDING CARD DEBIT MASTERCARD®

You will be provided with a Health Care Spending Card Debit MasterCard® that may be used to pay for certain Eligible Expenses directly from your HCSA, LHCSA, and/or DCSA. The Health Care Spending Card Debit MasterCard® allows for direct payment to qualified locations and providers and can be used at any approved location that accepts MasterCard®. Use of the Health Care Spending Card Debit MasterCard® is voluntary.

Important:
You should familiarize yourself with the specific products and services that are eligible for card use based on this Plan. Go to **www.myuhc.com** to learn how to get the most out of your Health Care Spending Card Debit MasterCard®.

Receiving Your Health Care Spending Card Debit MasterCard®

You will automatically receive two Health Care Spending Card Debit MasterCard®s. Read the terms and conditions found on the card insert and sign the back of your card. You may call the customer service number listed on the back of the Health Care Spending Card Debit MasterCard® to order additional cards.

Activating Your Health Care Spending Card Debit MasterCard®

If you choose to activate the Health Care Spending Card Debit MasterCard® you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. The card will be ready to use with funds available real time upon activation of the card within the first Plan Year. However, for future Plan Years the funds will not be available for use until the effective date of the future Plan Year.

If you decide not to activate the Health Care Spending Card Debit MasterCard®, simply destroy and discard both cards. However, you can be reimbursed for Eligible Expenses by completing a paper reimbursement form available from the HEWT or found on **www.myuhc.com** and as described under Section, *Requesting a Reimbursement from Your Flexible Spending Account* or for Eligible Health Care Expenses by using the automatic reimbursement (auto-rollover) feature described under the Section, *Automatic Reimbursement (Auto-Rollover)*.

Please note:
If you activate your card prior to the Plan effective date, you cannot use your card until the Plan effective date.

Qualified Locations and Providers

The Health Care Spending Card Debit MasterCard® may be used at any approved provider or merchant with a Point-of-Service (POS) bankcard terminal that accepts MasterCard® or your Health Care Spending Card Debit MasterCard® number can be entered online or on an order form, similar to using a credit card number. You can even use your Health Care Spending Card Debit MasterCard® to pay for a bill you receive in the mail if the merchant or provider accepts MasterCard®. Examples of qualified locations and providers include hospitals, physician and dental offices, vision care providers, retail pharmacy counters, and child and adult day care facilities.

You may choose to use your Health Care Spending Card Debit MasterCard® for mail order prescriptions or for eligible over-the-counter (OTC) supplies, materials and prescribed OTC medicines by going to an online pharmacy at Drugstore.com via **www.myuhc.com**. Additionally, your Health Care Spending Card Debit MasterCard® can be used at Walgreen's retail stores or at participating retailers as described under the Section, *Retailers with Inventory Information Approval System (IIAS)*.

Using the Health Care Spending Card Debit MasterCard®

In order to use the Health Care Spending Card Debit MasterCard®, you will need to enter 'credit' on the POS bankcard terminal just as if you were purchasing an item using a credit card. Each time the card is used for payment, you will sign a receipt. Your FSA and card are regulated by the IRS, therefore you should retain all itemized receipts generated from the Health Care Spending Card Debit MasterCard®, because certain payments must be verified and UnitedHealthcare may request this receipt from you to ensure that payment was made for a qualified health care or dependent care expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe the Health Care Spending Card Debit MasterCard® through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases real-time and automatically debits your FSA account based on the guidelines established by the IRS and your specific plan design as described under Section, *Health Care Spending Account* and *Dependent Care Spending Account*. A claim number is assigned to the transaction.

Eligible Expenses Reimbursed through the Health Care Spending Card Debit MasterCard®

Your card can be used for certain Eligible Dependent Care Expenses and Eligible Health Care Expenses including prescriptions copayments or out-of-pocket responsibility, eligible over-the-counter (OTC) supplies and, materials, prescribed OTC medicines and copayments, deductibles and coinsurance at locations such as doctor, dentist, eye doctor, clinic, hospital or other care providers associated with medical, dental, vision at UnitedHealthcare in-network providers. Additionally, your card can be used for out-of-network copayments if your copayment is the same as the in-network copayment. While in-network provider transactions can be used for coinsurance and deductibles the card does not determine patient responsibility or eligible benefits.

Partial Payment Authorization

Partial authorization capability allows you to use your Health Care Spending Card Debit MasterCard® with transactions amounts greater than the funds available in your HCSA or LHCSA for a portion of the transaction at providers or merchants that accept partial authorization. For example, if you purchase an item that costs $20 and you only have $10 remaining in your HCSA or LHCSA, the HCSA or LHCSA balance of $10 will be authorized towards the purchase and you are responsible for paying the remaining balance of $10 with another form of payment. **Note:** not all providers or merchants accept partial authorization.

Retailers with Inventory Information Approval System (IIAS)

IRS regulations require that retailers comply with IRS Inventory Information Approval System (IIAS) swipe technology as a method to identify and substantiate Eligible Health Care Expenses, per Section 213(d) of the Code. The IIAS allows you to use your Health Care Spending Card Debit MasterCard® to pay for 213(d) Eligible Health Care Expenses without having to provide any additional documentation or request reimbursement after a purchase is made, as transactions will be verified at the point of sale and payment will be made right from your HCSA or LHCSA. Additionally, IIAS compatibility allows you to use your Health Care Spending Card Debit MasterCard® at participating retailers to pay for both Ineligible Expenses and Eligible Health Care Expenses on the same transaction with Eligible Health Care Expenses being approved via the Health Care Spending Card Debit MasterCard® and remaining Ineligible Expenses may be paid using another form of payment. When you use your card at participating retailers, Eligible Health Care Expenses will be identified and noted on your receipt. You will not have to submit receipts for reimbursement as long as the purchases are made at a participating retailer and you use your Health Care Spending Card Debit MasterCard®. IRS guidelines still require you to save your itemized receipts as part of your tax records. You can see a full list of participating retailers at **www.sig-is.org**. If you go to a non-Participating retailer you can still buy Eligible Health Care Expenses that don't provide itemized sales receipts, however you will need to pay using another form of payment, and then submit receipts for reimbursement as described under the Section, *Requesting a Reimbursement from your Flexible Spending Account.*

Monthly Health Statements and FSA Yearly Statements

Explanation of Benefits (EOBs) will not be issued for card transactions. Instead, you will receive monthly health statements and an FSA yearly statement which will include your card activity. You will also be able to view card transactions on **www.myuhc.com**. If you note a discrepancy on the monthly health statement or FSA yearly statement, call the number on the back of your Health Care Spending Card Debit MasterCard® to resolve the issue.

Contacting a Customer Care Professional is easy.
Simply call our toll-free number at 1-866-755-2648 available 24 hours a day.

- Order Additional cards
- Report a lost or stolen card
- Get answers concerning Eligible Expenses or your account balances

HEALTH SAVINGS ACCOUNT INFORMATION (HEWT)

Health Savings Account

The HSA Component of the HEWT works in tandem with enrollment in a qualified high deductible health plan and permits you to make pre-tax contributions to a HSA. The HSA is maintained and administered outside of the HEWT with Health Equity, the HSA administrator. Your participating employer will also make contributions to the HSA on your behalf (see further information under Contributions section). Your HSA funds can be used for Eligible Health Care Expenses (see Eligible Health Care Expenses section below).

Who is Eligible

Employees who are enrolled in a HDHP are eligible for an HSA. You may also be asked to certify that you meet all of the requirements under Section 223 of the Code to be eligible to contribute to an HSA. These requirements include such things as not having any disqualifying coverage, and you should be aware that coverage under a Spouse's plan, including a Spouse's health FSA, could make you ineligible to contribute to an HSA.

If you elect an HCSA, you are not eligible to contribute to an HSA (or otherwise make contributions to an HSA), but you can elect the LHCSA option.

Contributions

Your annual contribution to the HSA is equal to the annual benefit amount that you elect. For 2023, if you have employee-only coverage in a HDHP, the maximum contribution you can make to an HSA is $3,850. If you have family coverage in a HDHP, the maximum contribution you can make to an HSA is $7,750. These limits are subject to annual adjustment by the IRS. These maximum amounts are prorated if you have not had coverage under a HDHP for the entire calendar year. For example, if you are beginning coverage under the HDHP as of October 1, 2023, you may contribute a maximum of $962.50 for employee-only coverage, or you may contribute a maximum of $1,937.50 for family coverage.

You can also make an additional catch-up contribution of $1,000 if you are age 55 or older. If you are eligible for a catch-up contribution, please contact Health Equity for more information about limits that may apply.

If you are an existing employee as of January 1 of the Plan Year, you will receive an employer contribution of $750 in your HSA if you have employee-only coverage in a HDHP or $1,5000 in your HSA if you have family coverage in a HDHP. These full amounts will be immediately available to you for Eligible Health Care Expenses.

If you are hired or rehired during the Plan Year, you will receive pro-rated monthly employer contributions of $62.50 in your HSA if you have employee-only coverage in a HDHP or $125 in your HSA if you have family coverage in a HDHP.

Eligible Health Care Expenses

You can use your HSA to pay out of pocket Eligible Health Care Expenses that are:

- Incurred for medical care, defined in Sections 106(f) or 213(d) of the Code for amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body including prescription medicine and drugs and over-the-counter medicine and drugs prescribed by a health care provider;
- Incurred while you are participating in the HDHP (including via COBRA continuation coverage); and
- Incurred during the Plan Year.

Please note that you are responsible for retaining the documentation that substantiates the use of your HSA funds for Eligible Health Care Expenses. If you are audited by the IRS, you will be required to produce these receipts.

Unused Funds at the End of the Year

You keep any unused funds in your HSA at the end of the year. The monies in your HSA belong to you – it is not a "use or lose" account.

Additional Information

Your HSA is considered to be an individual account that is held with and administered by Health Equity. For more information on how to use your HSA, including reimbursements from your HSA or changing your HSA contribution amounts, please contact Health Equity.

Your HSA is not an employer-sponsored benefit for purposes of ERISA. Your participating employer's role is limited to forwarding your pre-tax salary reductions and making contributions toward your account. Neither your employer nor HEWT administers or has discretionary authority over your HSA.

REQUESTING A REIMBURSEMENT FROM YOUR FLEXIBLE SPENDING ACCOUNT

If you do not activate your Health Care Spending Card Debit MasterCard® or choose not to use your card, you will need to submit a reimbursement form, called a request for withdrawal, to be reimbursed from your HCSA, LHCSA, and/or DCSA for the Eligible Expenses that have been incurred. A request for withdrawal form is available from the HEWT or can be found on **www.myuhc.com**. However, if the automatic reimbursement (auto-rollover) feature as described under Section, *Automatic Reimbursement (Auto-Rollover)* is turned "on," you will not have to submit a reimbursement form for certain HCSA and LHCSA expenses.

For reimbursement from your HCSA or LHCSA, you must include proof of the expenses incurred. Proof can include a bill, invoice, or an Explanation of Benefits (EOB) from any group medical/dental/vision plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical, dental and vision plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical/dental/vision plans are made.

For reimbursement from your DCSA, you must submit proof of the services rendered, such as a bill, receipt, or invoice and Social Security or Tax Identification Number of the care provider.

Only expenses which are incurred while you are a participant in the Plan may be reimbursed from an FSA. For the DCSA, if your employment terminates you can continue to request reimbursement for Eligible Dependent Care Expenses. The Plan provides that you may submit expenses incurred up to the date you terminate employment for reimbursement, and that those claims can be submitted up unto March 31 of the calendar year following the calendar year in which you terminate employment. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

You can submit a reimbursement form as often as monthly. You will be reimbursed for Eligible Expenses as long as the amount requested from either account is at least $50, except for reimbursement with respect to the last month of the Plan Year. Amounts below $50 will be accumulated and processed with future payments. However, if the automatic reimbursement (auto-rollover) feature as described under Section, *Automatic Reimbursement (Auto-Rollover)* is turned "on," you will not have to submit a reimbursement form for certain HCSA or LHCSA expenses.

If you have established a HCSA or LHCSA, your total annual contribution amount is available immediately. You can request reimbursement for Eligible Expenses up to your annual contribution amount (plus any carryover amount) as soon as such Eligible Expenses have been incurred.

If you have established a DCSA, only the amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account, you will receive only the amount in your account. As additional contributions are made to your account, outstanding reimbursements will be processed automatically.

Requests for withdrawal will be accepted and processed through March 31 of the following year for expenses incurred during the Plan Year. For the DCSA, if your employment terminates you can continue to request reimbursement for Eligible Dependent Care Expenses. The Plan provides that you may submit expenses incurred up to the date you terminate employment for reimbursement, and that those claims can be submitted up unto March 31 of the calendar year following the calendar year in which you terminate employment.

In accordance with IRS regulations, amounts contributed to your DCSA during the Plan Year but remaining in your account at the end of the processing period (March 31 of the following year) cannot be returned to you or used to reimburse expenses incurred in a subsequent Plan Year. These amounts are forfeited.

As of 2022, amounts contributed to your HCSA or LHCSA during the Plan Year but remaining in your account at the end of the processing period (March 31 of the following year), up to a maximum of $500, will be carried over and may be used to

reimburse expenses incurred in a subsequent Plan Year. Any remaining amounts in excess of $500 are forfeited.

Important:
Myuhc.com includes many features such as the options to:
- View Explanation of Benefits/Health Statements
- Utilize a savings calculator for FSA
- View your FSA summary page detailing contributions and amount left in your FSA
- View your FSA Claims Summary including claim transaction details

Automatic Reimbursement (Auto-Rollover)

Your employer has elected to have Eligible Expenses for medical, pharmacy, dental and vision claims which are not covered under your UnitedHealthcare administered plans automatically submitted to your HCSA for reimbursement. This eliminates extra paperwork and makes it more convenient for you to use your HCSA. Automatic reimbursement (auto-rollover) is turned "on" at the start of the Plan Year. You can turn automatic reimbursement (auto-rollover) of claims "off" or back "on" by going on to **www.myuhc.com**. All claims must still be verified and UnitedHealthcare may request additional substantiation.

However, if you have coverage administered through another carrier, the automatic reimbursement (auto-rollover) feature does not apply. Further, the automatic reimbursement (auto-rollover) feature does not apply to your domestic partner covered under your employer's group health plan, unless your domestic partner is your federal tax dependent for health coverage purposes, as defined under Section 105(b) of the Code. An FSA withdrawal request must be submitted for any other types of expenses such as dependent care expenses and any health expenses not submitted to your health benefits carrier.

CLAIMS PROCEDURES

Claim Denials and Appeals

If Your Claim is Denied

If a claim for benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID Health Care Spending Card Debit MasterCard® before requesting a formal appeal. UnitedHealthcare will try to resolve the issue over the phone, however, if you are not satisfied you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you think your claim should be paid; and
- any documentation or other written information to support your request.

You or your Dependent may send a written request for an appeal to:

UnitedHealthcare – Appeals
Attn Appeals
P.O. Box 981512
El Paso, TX 79998-1512

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the HEWT within 60 days from receipt of the first level appeal. The HEWT must notify you of the benefit determination within 30 days after receiving the completed appeal.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. The HEWT will review all claims in accordance with the rules established by the U.S. Department of Labor. The HEWT's decision will be final.

The table below describes the time frames in an easy to read format which you and UnitedHealthcare are required to follow.

Claim Denial and Appeals	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**

Claim Denial and Appeals	
Type of Claim or Appeal	**Timing**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
▪ if the initial claim is complete, within:	**30 days**
▪ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The HEWT must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

WHEN PARTICIPATION ENDS

You will cease to participate in the Plan as of the earlier of:

- The date on which the Plan terminates.
- The date your employment with the Company ends.
- The date you cease to be an eligible employee.
- The date you fail to make a required contribution under the terms of the Plan.
- The date you retire, unless the plan is available for retired persons and you are eligible for the plan.

Health Care Spending Account and Limited Health Care Spending Account

You may submit a claim for reimbursement of Eligible Expenses which were incurred during the Plan Year of employment termination, as long as those expenses were incurred

prior to the date of your termination. Any such claims must be submitted on or before March 31 of the next Plan Year.

COBRA Continuation Coverage (COBRA)

The HEWT may be required to offer continuation coverage in certain cases as a result of the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. Ask the HEWT to find out if and how this continuation coverage and continuation coverage under USERRA described below applies.

In general, COBRA continuation coverage must be offered with respect to a participant's HCSA or LHCSA if the participant has a positive balance in such account at the time of a qualifying event such as termination of employment (other than by reason of gross misconduct) or reduction in work hours. A "positive balance" for this purpose generally means that the contributions made to the account prior to the qualifying event exceed the eligible claims for reimbursement submitted prior to the qualifying event. If this COBRA continuation coverage is available to a participant who experiences a qualifying event and continuation coverage is elected by the participant, such coverage will cease at the end of the Plan Year in which the qualifying event occurs and coverage cannot be continued into the next Plan Year. Premiums for such continuation coverage (i.e., contributions to the account) will be paid by the participant on an after-tax basis unless otherwise permitted by the HEWT on a uniform and consistent basis plus a 2% administrative fee or other cost as permitted by law.

Uniformed Services Employment and Reemployment Rights Act

An employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the employee and the employee's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA").

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution (i.e., contributions to the account) for the HCSA or LHCSA. If an employee's s Military Service is for a period of time less than 31 days, the employee may not be required to pay more than the regular contribution amount (i.e., contributions to the account), for continuation of the HCSA or LHCSA.

An employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the employee's absence from work; or
- the day after the date on which the employee fails to apply for, or return to, a position of employment.

Regardless of whether an employee continues the HCSA or LHCSA, if the employee returns to a position of employment, the employee's HCSA or LHCSA and that of the employee's eligible dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an employee or the employee's eligible dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue the HCSA or LHCSA under USERRA.

Dependent Care Spending Account

You may submit claims for the Eligible Expenses you have incurred during that Plan Year before your termination date against what is in your DCSA when you leave employment. The Plan provides that you may submit expenses incurred up to the date you terminate employment for reimbursement, and that those claims can be submitted up unto March 31 of the calendar year following the calendar year in which you terminate employment.

IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

This section includes information on the administration of the Plan, as well as information required of all Summary Plan Descriptions by ERISA. While you may not need this information for your day-to-day participation, it is information you may find important.

Please note:
The DCSA is not subject to ERISA. Only the HCSA and the LHCSA are subject to ERISA and the terms described below.

Plan Sponsor and Administrator

The Plan is sponsored by the companies that are participating employers in the Hanford Employee Welfare Trust. Please see the Plan Document, Summary Plan Description and Administrative Wrapper Hanford Employee Welfare Benefit Plans for a complete list of participating employers.

The Board of Trustees of the Hanford Employee Welfare Trust is the Plan Administrator of the Hanford Employee Welfare Trust and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Board of Trustees of the Hanford Employee Welfare Trust,
Hanford Employee Welfare Trust
c/o Hanford Mission Integration Solutions, LLC
P. O. Box 943, MSIN H2-23
Richland, WA 99352
(509) 372-8284

Claims Administrator

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone, fax or in writing at:

United HealthCare Services, Inc
185 Asylum Street
Hartford, CT 06103-3408
(866) 249-7606

FAX No.: (915) 781-1085

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process - FSA Plan
Jason Froggatt
Davis Wright Tremaine LLP
920 Fifth Avenue, Suite 3300
Seattle, Washington 98104-1610
(206) 757-8045

Legal process may also be served upon a Plan Trustee or the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	The Hanford Employee Welfare Trust Flexible Spending Account is a component of the Hanford Employee Welfare Trust
Plan Number:	550
Employer ID:	33-0691003
Plan Type:	Welfare benefits plan
Plan Year:	January 1 – December 31
Plan Administration:	Self-Insured
Source of Plan Contributions and Funding:	The Plan is funded out of the general assets of the Plan Sponsor based on the salary reduction elections made by participating Employees.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all documents governing the HCSA and LHCSA – including pertinent insurance contracts, trust agreements, collective bargaining agreements (if applicable), and a copy of the latest annual report (Form 5500 series) filed with the Internal Revenue

Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration; and

- obtain copies of all documents that govern the operations of the HCSA and LHCSA and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual reports (Form 5500), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue HCSA or LHCSA benefits for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit under the HCSA or LHCSA is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section, *Claims Procedures*, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document or the latest annual report from the Plan, and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor,

listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.